METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Description of How Rates are Set for Residential Psychiatric Treatment Centers (continued)

A minimum facility-specific per diem capital amount, or floor, will be used for those facilities that:

- are unable to provide cost report information to the Department for use in the calculation of a facility-specific per diem capital rate, or
- are fully depreciated, or
- have a facility-specific capital per diem amount that is less than the minimum, or floor, per diem capital rate.

The minimum facility-specific per diem capital amount, or floor, will equal 10 percent of the statewide median capital per diem amount, regardless of the payment blend.

Therefore, capital reimbursement, including the floor, is calculated as follows:

Effective July 1, 1991:

25% of the Statewide Median Per Diem

+

The greater of 75% of the facility-specific per diem or 10% of the Statewide Median per diem.

Effective July 1, 1992:

35% of the Statewide Median Per Diem

+

The greater of 65% of the facility-specific per diem or 10% of the Statewide Median per diem.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Description of How Rates are Set for Residential Psychiatric Treatment Centers (continued)

Effective July 1, 1993:

50% of the Statewide Median Per Diem

+

The greater of 50% of the facility-specific per diem or 10% of the Statewide Median per diem.

Both the statewide median and facility-specific per diem fixed capital amounts are inflated annually, effective July 1 of each year, using the latest one year District Comparative Cost Multiplier for the Central Region, Class A Construction, in the January edition of the Marshall Valuation Service, published by Marshall and Swift (subject to upper limit requirements). Rates will be set prospectively prior to the start of the state fiscal year and not readjusted following the start of the state fiscal year using later available forecasts or actual inflationary changes.

The facility-specific per diem operating and movable capital amounts are inflated annually, effective July 1 of each year, using the lesser of the available Data Resources Inc. (DRI) HCFA-type Hospital Marketbasket Index's forecast for the midpoint of the upcoming state fiscal year or the latest Health Care Financing Administration (HCFA) proposed update factor for non-PPS (exempt) hospitals published in the Federal Register or in Federal legislation whichever is later, prior to the start of the state fiscal year. Rates will be set prospectively prior to the start of the state fiscal year and not readjusted following the start of the state fiscal year using later available forecasts or actual inflationary changes.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Description of How Rates are Set for Residential Psychiatric Treatment Centers
(continued)

New residential psychiatric treatment centers (this does not include facilities having a change in ownership) lacking 12 months of cost report information shall receive the statewide median per diem operating and movable capital rate plus the statewide median fixed capital per diem amount. After submittal of the first full year's cost report, capital payments will be based on a blend of the facility-specific fixed capital per diem and a statewide median fixed capital per diem amount according to the same blend percentage applied to all other facilities. The facility-specific fixed capital per diem amount and the facility-specific per diem operating and movable capital amount will be calculated from the first full year's cost report information.

Out-of-state facilities for which the Department has on file a fiscal year 1989 or more recent cost report, shall be reimbursed the same as in-state Oklahoma residential psychiatric treatment centers. Residential psychiatric treatment centers for which the Authority does not have a fiscal year 1989 or more recent cost report will receive the statewide median amounts for both components of the residential psychiatric treatment center rate.

Effective July 1, 1998, reimbursement for residential psychiatric treatment centers (RPTCs) will be paid according to facility peer group, using the statewide median per diem amounts for both components of the residential psychiatric treatment center rate. Out-of state facilities will be reimbursed in the same manner as in-state residential psychiatric treatment centers

1. **Definitions**

a. **Hospital-based facility.** A RPTC that is operated by a hospital (i.e., under the common ownership, licensure or control of a hospital), and is fully accredited by JCAHO or AOA as a psychiatric facility or program. The RPTC must also be licensed as a residential child care facility.

b. **Freestanding facility.** An independent RPTC (i.e., not part of a hospital or any other facility) that is fully accredited by JCAHO or AOA as a psychiatric facility or program. The RPTC must also be licensed as a residential child care facility.

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c. **Community –Based facility.** A RPTC that is independent (i.e., not part of a hospital or any other facility), and is fully accredited by JCAHO or AOA as a psychiatric facility or program. The RPTC must also be licensed as a child placement agency.

2. **Peer Groups** - For payment purposes, there are two peer groups: a) Hospital-based and freestanding; and b) community-based RPTCs.

a. **Hospital-Based and Freestanding RPTCs** - The statewide median component rates were calculated using 1989 audited cost reports according to the methodology described on Attachment 4.19-B, page 13. Payment will be an all-inclusive per diem. The facility must furnish either directly or under arrangements, all non-physician services, including prescribed drugs.

b. **Community-Based RPTCs** - The statewide median component rates were calculated using 1990 audited cost reports according to the methodology described on Attachment 4.19-B, page 13. Payment will be made for routine per diem services, exclusive of ancillary and physician services. Ancillary and physician services will be reimbursed separately on a fee for service basis.

3. **Adjustments**

Effective July 1, 1998 peer grouped statewide median operating and movable equipment per diem diem rates for RPTCs will be updated annually using the DRI fourth quarter index's forecast for the midpoint of the upcoming state fiscal year (e.g., 2.4%) and the HCFA PPS-type Hospital marketbasket weight assigned for compensation (e.g., 61.39%). Example: FY99 rate = FY98 statewide per diem operating and movable equipment rate x update factor (1.0147).

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

1. Payment of Deductible and Coinsurance for Medicare Part B Claims.

Payment is made at a rate of 94 percent of the deductible and 75 percent of the coinsurance.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

1. Family Planning Center Services

Payment will be made at a rate established by the Department of Human Services for each unit of services described in Attachment 3.1-A, Page 1a-7, and Page 1a-7.1, and Attachment 3.1-B, Page 3a-2 and Page 3a-2.1. Payment rates will take into consideration the prevailing rates for same and similar services in the community. Reimbursement of Norplant is made on a global fee basis. The State pays the provider an amount equal to the July 1, 1991 distributors' list price for Norplant materials and an amount equal to 43 percent of the Norplant System Kit price for Norplant insertion and removal.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Child Health Center Services

Each rate was established after an analysis of the component factors and the current allowable charges for those components. An average cost per day of comparable services in a non-child health center setting was established and then converted to an encounter rate. Rate modification for these procedures will be reviewed as comparable component procedure allowables are modified, and as eligible providers provide documentation which indicates the rates should be adjusted to provide reasonable reimbursement for the comprehensive procedures. The payment will not exceed the total allowable amount for comparable services under comparable circumstances under Medicare in the aggregate.

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School Based Health Services

Payment is a negotiated, all-inclusive encounter rate. School Based Health Services, payment is made in accordance with the established fee schedule rate described in Attachment 4.19-B, pages 25d and 25e. The encounter rates and fee schedules are maintained in the agency computer database.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Early Intervention Services

Early Intervention Services, payment is made in accordance with the established fee schedule rates described in Attachment 4-19-B, page 11, page 16, and pages 25d and 25e. The encounter rates and fee schedules are maintained in the agency computer database and the Agency library.

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Payment for Organ Transplant Procedures

Effective for services provided on and after December 1, 1992, payment for physician care, services and supplies is made in accordance with the Medicare Physician Payment Reform Methodology. Reimbursement rates are established at 75 percent of the Medicare allowable. This methodology does not apply to rates for anesthesia services, obstetrical services for delivery, antepartum and postpartum care and EPSDT screenings. Rates for anesthesia services, obstetrical services for delivery, antepartum and postpartum and EPSDT screenings are set in accordance with the statewide procedure based reimbursement methodology established by the state. Reimbursement limits per procedure are determined based on a review of previous payment amounts set by DHS and Medicare methodologies. The base limits for each procedure were established through comparison of the 75th percentile of both DHS and Medicare. The lower of DHS of Medicare was chosen as an initial limit. Comparable procedures were then subjected to a procedure by procedure analysis in terms of complexity or degree of difficulty. A Procedure Review committee consisting of medical professionals made the final determination. Adjustments to the payment limits on an individual procedure may be considered by the Procedure Review Committee on a periodic or as needed basis as requested by medical providers.

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